Smith ScholarWorks

Theses, Dissertations, and Projects

2009

Standards of care : transgender/genderqueer clients' experiences with mental health workers

Hunter Greenwood Swanson
Smith College

Follow this and additional works at: https://scholarworks.smith.edu/theses

Part of the Social and Behavioral Sciences Commons

Recommended Citation

Swanson, Hunter Greenwood, "Standards of care : transgender/genderqueer clients' experiences with mental health workers" (2009). Masters Thesis, Smith College, Northampton, MA.
https://scholarworks.smith.edu/theses/1150

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Hunter Greenwood Swanson
Standards of Care: Transgender/ Genderqueer Clients' Experiences with Mental Health Workers

ABSTRACT

This qualitative, exploratory study sought to explore the experiences of transgender and genderqueer clients with the mental health system. Its purpose is to introduce the voices of the clients themselves into a body of literature that is currently largely dominated by professionals outside the trans community.

Twelve people who self-identify as trans or genderqueer were recruited through postings on mailing lists and in queer-friendly spaces in Massachusetts and agreed to participate in hour-long interviews detailing their experiences in therapy as well as their feelings about their gender identities. Questions addressed quality of care received, length of time spent in therapy, suggestions for improved care, and participants' feelings about the gatekeeper role played by therapists in relation to surgical letters and about the inclusion of gender identity disorder as a diagnosis in the DSM.

Participants reported mixed experiences in therapy, suggesting qualities that determined their assessment of a given therapist. Many took issue with current standards of care and suggested future changes to the existing system.

STANDARDS OF CARE:

TRANSGENDER/GENDERQUEER CLIENTS' EXPERIENCES

WITH MENTAL HEALTH WORKERS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

Hunter Greenwood Swanson

Smith College School for Social Work
Northampton, Massachusetts, 01063

2009

ACKNOWLEDGMENTS

This thesis could never have come together without the numerous people who have helped, supported, and encouraged me in my work throughout the year. I would like, first of all, to thank the twelve participants whose words and experiences make up the meat of this project. It would not have happened without your participation and willingness to share your stories. Thanks also to Cara, for impeccable advising, a sense of humor, and timely reassurances that I was not a hopeless case.

Thanks to my friends and fellow students, who were always quick to provide commiseration, recruitment help, encouragement, and distraction (though not necessarily in that order). To Sarah and Hosie, for all your help and support (as well as the roof over my head).

And of course, thanks especially to my family. To Mom and Dad, who have been unwavering in their belief in me since I was polishing apples on the farm. To Adrien, whose long-distance phone calls have been my salvation and who I admire more than anyone else I know. Finally, and most of all, to Kathryn, who has seen me through procrastination, frustration, and a good deal more, and still decided to stick around. Kathryn, I love you, and feel lucky every day to be your husband.

A nod of the head, at last, to the ghost of Calvin Coolidge, and the broken foot that kept me cloistered in my office long enough to get this thesis done.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS…….. *ii*

TABLE OF CONTENTS…….. *iii*

CHAPTER

I. INTRODUCTION……..... 4

II. LITERATURE REVIEW…….. 10

III. METHODOLOGY……... 30

IV. FINDINGS……. 36

V. DISCUSSION…… 75

REFERENCES…….. 89

APPENDICES

Appendix A: Human Subjects Review Board Permission Letter…….. 94
Appendix B: Screening Questions……..... 96
Appendix C: Informed Consent…… 97
Appendix D: Additional Resources Pamphlet……100
Appendix E: Interview Guide……104

CHAPTER I

INTRODUCTION

Although homosexuality was removed from the Diagnostic Statistical Manual (DSM) as a mental illness in 1973, Gender Identity Disorder (GID) remains, and is likely to remain through the publication of the DSM V. Since its inclusion as a diagnosis, GID has been a topic of controversy among members of the trans community as well as psychiatric and medical professionals. Those who advocate its removal assert that, like the diagnosis of homosexuality before, it serves to impose pathology upon identities that are not socially sanctioned and in so doing acts as a disservice to those who must depend upon a label that connotes illness in order to be eligible for life-changing surgeries and hormones. Others, who feel that it is appropriate to retain the diagnosis, argue that to remove it would be to eliminate standards that help professionals to determine who would best be served by these interventions and in so doing would, in fact, make such services less accessible for those who truly need them. Moreover, the existence of a GID diagnosis also allows for a distinctly labeled population – a

fact, some suggest, that furthers the possibility for much-needed research. Additionally, there are those who believe that a desire to live as a gender different from that assigned at birth is within itself pathological and that, particularly in children, the best response to such an individual is immediate and intensive aversion therapy, or other such technique designed to encourage conformity with one's assigned gender role.

Regardless of the motivation for its current inclusion, the diagnostic category of GID greatly increases the likelihood that a person who is transgender or gender variant will at some point seek the services of a therapist or other mental health professional. For some, this is a purely practical decision; the Harry Benjamin Standards of Care, introduced in 1979 to standardize the treatment of transsexuality, recommends that surgeons (and in some cases, endocrinologists) require letters from one or several therapists, attesting that an individual is, from a psychiatric point of view, an appropriate candidate for transition-related procedures. Others may seek therapy as a source of support during transition, or for reasons that may be entirely unrelated to gender identity.

As will be seen in the literature review included below, there has been a considerable amount of literature devoted to the issue of gender identity, and

authors have expressed a range of viewpoints regarding the methods by which transgender/transsexual clients should be treated. In spite of the availability of such literature, there are comparatively few works that allow for the voices and experiences of these clients themselves to be heard. Although autobiographies of transpeople chronicling their journeys have become more numerous in recent years, much of the available professional and empirical literature fails to account for this important facet of the research. This study is a small attempt to begin to offset that balance, and to allow the clients themselves to weigh in on the degree to which they have felt that therapists they have seen have been informed about issues relevant to their lives, as well as the effectiveness of current standards of care in achieving their stated aim of "maximiz[ing] overall psychological well-being and self-fulfillment" of trans clients.

The purpose of this study is to address the following question: What are the experiences of trans/genderqueer people with mental health professionals before, throughout, and after transition? An attempt to answer this question will make use of a qualitative design utilizing open-ended questions within a semi-structured interview. The sample for this study includes twelve people who identified as trans or genderqueer, or who considered their gender identity to be non-normative in some respect. All of these participants had been in therapy at

some point during or after transition and were willing to be interviewed for roughly an hour about their experiences in therapy. Specific issues explored included gender identity development, participants' feelings about their gender identity and its place in their lives, participants' experiences in therapy and their feelings about those experiences, participant views on both the gatekeeper role played by therapists in the provision of letters for surgery and the inclusion of gender identity disorder as a diagnosis in the DSM.

From the outset, a definition of terminology is necessary for clarification. Trans identities, which may involve shifting pronouns and a reconceptualization of physicality, can be semantically complex. Self-definition is, for many, a major aspect of transition. As a result, people who do not neatly fit within the gender binary may use a range of terms with which to self-identify; two people might use the same word but conceptualize its definition differently. I will therefore make every effort in the course of this research to describe its participants using language they themselves have designated. However, in speaking more generally throughout the paper, I will, for simplicity's sake, use the term trans or transgender to refer to individuals whose gender differs from that which was assigned at birth, regardless of what interventions have been undertaken (name/pronoun change, surgery, hormones) to alter appearance or social

identity. I will use the term genderqueer as a broader umbrella encompassing any individuals who present or identify as outside the gender binary but who do not necessarily consider themselves to be transitioning.

This study was written with several primary purposes in mind. Although limitations in time and in the number of available subjects prohibit this project from being an exhaustive study, the overall paucity of literature on the topic serves as a compelling argument for initial investigation. Although awareness of issues specific to the trans and genderqueer communities (as well as of the very existence of these communities) has increased in recent years, there remains a general shortage of available information, even for clinicians who would like to educate themselves. The literature that does exist is often contradictory, outdated, and/or extremely pathologizing. Noticeably absent are the voices of these clients themselves, the introduction of which would be valuable in balancing the often pejorative tone of the white heterosexual male practitioners contributing the bulk of research currently available. These voices could work to dispel misconceptions and reframe some of the pathology surrounding issues of gender identity.

It is my hope that this project can help illuminate some trends in areas in which clinicians can increase their education and sensitivity to better serve

clients whose gender identities fall outside of a neatly defined binary. I also hope that this thesis may serve as a resource for those who act as advocates for social policy change, and that its findings may aid in efforts to improve access to care and increase the civil rights afforded to people within the trans community.

CHAPTER II

LITERATURE REVIEW

This review will endeavor to provide a summary of the existing literature addressing the treatment of individuals diagnosed with Gender Identity Disorder. It will illuminate trends in the ways in which people with GID have been viewed and defined by the medical establishment over the past several decades, and in doing so will examine biases embedded in the writing throughout. There will also be an inquiry into the more recent writings (some by transpeople themselves) and an exploration of the contrasts between trans-positive therapeutic approaches and more traditional aversive therapies. Due to the dearth of available literature, this review will utilize sections of books and newspaper publications as well as peer review journals.

The literature reviewed in this section will be divided into five categories. The first, comprised primarily of older (1970's-1980's) writings, provides some historical basis by detailing traditionally approved methods for

dealing with trans-identified clients and the justifications of these methods. The second section will examine attitudes towards surgical interventions, illuminating the pervasive tendency even of trans-supportive clinicians to think along strict binary lines, advocating an "all-or-nothing" approach that disenfranchises those who do not strongly identify as either male or female. The third section will incorporate readings from more recently emerging voices, including those from within the queer community who decry trans identities as anti-feminist and self-hating. The fourth section will look at the viewpoints of trans/genderqueer people and their allies, and address the contribution made by this community to the literature that gauges its viability. Finally, the fifth section will discuss current controversy surrounding the existence of Gender Identity Disorder as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and review more recent literature, advocating affirmative treatment for transgender clients while examining current roadblocks to the provision of competent and effective care.

Narrow Lenses: History and Pathology

The 1970's saw a dramatic rise in literature concerning trans-identified individuals, and many of these shared several common themes. With the

removal of homosexuality from the DSM in 1973, there seems to have been a concurrent increase in focus, particularly in children, on so-called cross-gendered behaviors. These behaviors were viewed by prominent researchers not only as signs of an emerging trans identity but also as behavioral markers that could pinpoint an up-and-coming homosexual. Several relevant articles illustrate the dialogue that was occurring at this time. George Rekers publicized one case in particular, in which he justified a punitive course of treatment for a child, "Kraig," who identified as female in spite of his assigned male sex. Among reasons given for this treatment was behavioral normalization to reduce the likelihood of a transsexual or homosexual outcome. Therapeutic interventions involved modification of parental response; Kraig's parents were instructed at first to ignore him entirely when he engaged in play with stereotypically feminine toys (dolls, dress-up clothes) and to reward him when he played with masculine ones (guns, military vehicles, an electric shaver) with praise and attention. These interventions were eventually made more extreme, and Kraig was either put into isolation or received physical punishment (a 'swat') from his father if he was caught engaging in any sort of verbal or physical 'feminine' behavior, while he was rewarded for engaging in masculine behaviors with candy bars and toys. Rekers and colleagues declare proudly that their treatments

eventually resulted in Kraig's near-total disavowal of anything he had been trained to perceive as feminine (Rekers, 1974).

This article spurred a response, a few years later, by Nordyke, Baer, Etzel, & Leblanc (1977), who took issue with the ethical implications of the course of treatment employed in the case of Kraig. Specifically, this article questions the validity of treating behaviors that are simply out of synch with society's expectations rather than inherently maladaptive. The authors cite as an example pacifists and feminists, who are also susceptible to society's scorn, but who claim the right to advocate for social change rather than altering their beliefs to fit the prevailing views of those around them. "Not every social pressure" the authors note, "…needs to be taken to define a deviancy that thereby needs treatment" (Nordyke et al., 1977, p. 554). Additionally, the article questions the basic assumptions regarding what constitutes a 'masculine' or 'feminine' toy or behavior, noting the violent themes contained in the majority of the 'masculine' toys as well as the irony of seeking to cure a child's emerging homosexuality by forbidding him any social contact with girls (Nordyke et al., 1977). In spite of these arguments, the issue of transsexuality itself is hardly addressed. The authors advocate a manner of treatment in which the only symptoms or behaviors treated are those that would be considered inappropriate for either

girls *or* boys, arguing for less rigid sex role stereotyping without taking a stance on whether or not adult transsexuality is a fate to be avoided at all costs (Nordyke et al., 1977). In the very same issue of this particular journal, Rekers issues a quick counter-argument, in which he states that a parent's wish to cure a child of homosexuality because he or she opposes it on moral grounds is just as appropriate as wishing to curb a child's cheating or lying behaviors for the same reason. He also states, without providing any evidence to back this assertion, that "The most adaptive psychological state appears to be the one in which the essential (biologically mandated and socially defined) distinctions between the male and female roles are mastered by the child" (Rekers, 1977, p. 560). Other writers of this period echo Rekers' attitude, turning to pathology to explain the behaviors of their trans-identified clients without making any inquiry into external stressors that might be contributing to overall distress. Overt sexism is also readily apparent, as in the case of a survey of trans-identified clients seeking sexual reassignment surgery (SRS). In this article, the author explains the prevalence of male-to-female (MtF) SRS over those performed on female-to-male (FtM) patients by stating that "consummation of intercourse on the part of a female…requires little more than an orifice; therefore, surgical male-to-female reassignment is a far less complicated procedure" (Rekers, 1977, p. 560).

SRS & the Quest for Legitimacy

This simplistic assumption that the be-all, end-all of a woman's sex life is the existence of an orifice, while crude and rather extreme, actually underscores a common meta-narrative running beneath the discourse surrounding trans people and SRS. Transwomen are repeatedly labeled narcissistic, hysterical, psychotic, or schizoid for seeking genital reconstruction. Their inclinations towards 'autocastration' are deeply disconcerting to many clinicians; the issue here is not whether a satisfying surgical result can be achieved, but why it would possibly be desired. Conversely, FtM individuals have received considerably less pejorative labeling. Their desire to live 'as men' is more easily understood in the face of pervasive sexism. In fact, many female-assigned people exhibiting 'cross-gendered' behaviors fail to meet the criteria for a GID diagnosis because of the specific phrasing that the desire to change genders must not be related to the perceived social or cultural advantages of the other sex. No, the sticking point here is the impossibility of constructing a penis that could possibly approach the quality of 'the real thing.' The permanence of SRS makes many researchers anxious; a 1982 article warns that the "68-86% success rates" reported for these surgeries may be misleading. It cautions that

long-term study will likely reveal that "non-transsexual" patients are being provided erroneously with surgeries when they could be 'cured' through less invasive psychotherapy (Lothstein, 1982). This viewpoint, which sets up therapy as an aversive technique designed to prevent a transsexual outcome, makes it easy to see why many trans people may be distrustful of the mental health system (Dean, et al., 2000).

Backlash: I Know What You Really *Are*

Regardless of the stance held by researchers and clinicians, SRS (as well as a spectrum of other interventions ranging from hormones to binding/packing devices that flatten the breasts to create a more 'masculine'-appearing chest and act as a prosthetic penis worn beneath one's clothes, respectively) have enabled a significant number of transpeople to live and interact socially in a way that reflects their gender identities. The existence of fully-passable trans men and women in mainstream culture is unsettling for many, as it challenges some basic assumptions about the destiny imposed by biology and the ways in which we think about gender. Some of the most fervent attacks against the legitimacy of trans identities have come not from psychiatric circles but from the queer communities which many trans people once called home. An article published

in 2000 in the popular lesbian-oriented magazine "On Our Backs" exemplifies this reaction by painting transpeople as practitioners of 'stealth politics,' using their identities to manipulate their way (in the case of transwomen) into women's spaces and, through the effort of 'passing,' display a profound lack of understanding of the basic principles of feminism by attempting to take on superficial 'feminine' characteristics. The author of this article goes on to make the comparison that if she, as a white woman, decided to identify arbitrarily as black and attempt to infiltrate the spaces of people of color, it would be comparable to a transwoman asking for acceptance in a women's space (Ruby & Mantilla, 2000). This comparison is used almost word for word in an interview with the notoriously anti-trans (and covertly homophobic) Kenneth Zucker that aired this spring on NPR, illustrating the pervasive nature of transphobia in mainstream North America (Spiegel, 2008). Clearly, while there is an increasing push for anti-discrimination laws to be extended to include gender identity and although the Pride parades of most cities include a transgender float or two, it is still clinically acceptable to question the validity of trans identities – an unfortunate fact, given the gatekeeping status assigned to mental health workers upon which access to life-changing surgeries and hormones depends.

Self-Advocacy and the Work of Allies

In recent years, the voices of transpeople themselves have begun to emerge in a surge of memoirs, theoretical texts, and novels. Kate Bornstein and Jamison Green are among the articulate trans people who have written comprehensively and accessibly about the reality of trans experiences while examining the fear and disgust with which deviation from the gender binary is typically greeted in popular media as well as research-based texts (Bornstein, 1994; Green, 2004). Bornstein in particular works to expose the fallacy of a rigid gender binary that takes its toll on the happiness of all people, not just the gender-disenfranchised. Recent literature has also begun to call into question the effects of deeply ingrained homophobia and transphobia on individuals struggling with gender identity development. The realization of just how unwelcoming society can be to someone who is genderqueer (as evidenced by public shaming, the employment of 'corrective' techniques, social ostracizing and alienation from one's family of origin, not to mention the institutionalized discrimination that continues to be condoned and even encouraged on a federal level) is, as several authors point out, a viable reframing of previously-held beliefs that it was an individual's 'deviant' gender identity, rather than a society that does not allow for gender fluidity, that was the cause of distress and

pathology in transgendered clients (Pazos, 1999). External stressors are many and often overwhelming, even for clients with considerable amounts of privilege. When additional target identities (as in the case, for instance, of trans people of color or that of people with inadequate economic resources) are superimposed, it is remarkable that more transpeople are *not* buckling under the stress of day-to-day existence (Wright, 2001).

The lack of mirroring available for young people who find that their gender identities differ from those of their peers is an inevitable source of distress. It is therefore vitally important that the voices of trans and genderqueer people continue to be heard. The preface to one recent article encompassing an extended first-person narration from a self-described "plainclothes" MTF individual states that:

> Personal narratives can also offer professionals feedback about how their services are experienced. By creating an open dialogue, these stories allow controversial issues to be addressed more honestly, and harmful practices to be distinguished from helpful ones. The opportunity to tell one's story can be an empowering and healing event. The first-person account also helps shift our attention from pathology to adaptation. When those who literally ''live the life'' are willing to speak out, they might be better advocates for themselves than professionals, who are usually seen as the experts (Glenn, 1999, p. 84).

This point is, I believe, a crucial one, and it is in the interest of allowing the personal narratives of people who have traditionally been shunned, misinterpreted, or silenced to begin to shape their own treatment that I am interested in undertaking this research. The choice of subject matter came about not solely because I myself am trans, but because there are legions of trans and genderqueer people in this country who do not share my educational and social privilege but who know from personal experience the harm inflicted by clinicians such as Zucker and his colleagues, who see trans identities as failures of a psychiatric system to curb feelings and expressions that fall outside a narrowly defined social norm.

Standards of Care: Beyond Harry Benjamin

With the emergence of the voices of transpeople into the public sphere has come an increased interest in culturally competent, affirmative care for those with non-traditional gender identities. Recent literature provides information to clinicians interested in working with trans and gender non-conforming clients. (Carroll & Gilroy, 2002, Mallon, 1999, Bockting et al, 2006). These articles, representing various viewpoints and schools of thought, set down parameters for ethical, sensitive, and appropriate care, though the degree to which a given

clinician subscribes to any of these guidelines is not by any means consistent or universal (Hale, 2007).

Efforts to put into practice consistent parameters to define appropriate treatment for transpeople have been ongoing for quite some time. The Harry Benjamin Standards of Care (SOC), first published in 1979 by the international organization now known as the World Professional Association for Transgender Health (WPATH), served as an attempt to establish clinical standards that would guide the treatment of transsexual patients. The SOC, while in some ways making it easier for transpeople to access appropriate services, also set up obstacles before the attainment of such services. For example, clients seeking hormonal or surgical intervention were now required to present their doctors and surgeons with several letters signed by psychiatrists, indicating their viability as candidates for treatment. (Hanssmann, Morrison & Russian, 2008, p. 7). Recent literature joins members of the trans community in criticizing the SOC for solidifying the gatekeeper status assigned to would-be providers, as well as the stringent requirements "placing restrictions on eligibility for surgical intervention without empirical evidence that such rules are necessary" (Carroll & Gilroy, 2002, p. 237). The mere existence of the prerequisites set forth by the SOC is problematic in that it creates "a category whose members are granted far less

autonomy than is given to any other category of adult prospective patients" (Hale, 2007, p. 493). In a 1999 article, Gerald Mallon goes further, making note of the negative effects a pathologized identity can have upon these clients themselves:

> Many transgendered persons believe that heterosexually-oriented social workers still harbor the heterocentric assumption that it is less than normal or less preferable to be transgendered. Some social workers…believe that somewhere in the transgendered person's system you can find the roots or the cause of transgendered identity, and that it secretly has something to do with family dysfunction or childhood sexual abuse.[1]

This criticism highlights an argument that emerges as an increasingly common theme in literature relating to the care of transgendered clients. The manner in which a non-traditional gender identity and expression should be perceived and addressed by the medical and psychiatric community is a matter of contention, not only within scientific circles but among transpeople themselves. Gender Identity Disorder was first incorporated into the DSM IV in 1980, the same year that homosexuality was removed as a mental disorder, ostensibly under the auspices of creating visibility and the possibility of further research, while providing clinicians with a set of diagnostic criteria to help them

[1] Mallon (1999), p. 12

to effectively recognize and treat a relatively small population (Spitzer & Zucker, 2005). There were those, however, who questioned these stated motives, and saw the inclusion of GID as an attempt to continue to pathologize gender-nonconforming behavior in the absence of a homosexual diagnosis, and to provide excuses to psychiatrists to 'treat' these gender-different children by enforcing traditional sex role conformity (Bern, 2003).

There are those (both within and outside the trans community) who argue that the continued inclusion of Gender Identity Disorder (GID) as a psychiatric condition in the DSM is somewhat of a necessary evil; a diagnosis can be a passport to needed services and lend legitimacy to trans identities (Hausman, 2003). Countering this argument, however, are those who attest that the existence of GID as a diagnosis is in many ways acting counter to its stated objective. Citing legal obstacles faced by transpeople in the pursuit of standard (non-trans-related) medical care, institutionalized discrimination, abuse of power by clinicians, and the use of diagnosis by groups with clear political agendas (such as NARTH, or the National Association for Research and Therapy of Homosexuality) to further stigmatize an already-marginalized community, many of these articles point out the ways in which a GID diagnosis systematically fails to provide its recipient with many of benefits that usually come with a mental

illness label (Ben-Asher, 2005, Hong, 2002, Spade, 2003, Dean, 2000, Frye & Minton, 1996, Green 1994, LGBT Health 2001, Shaffer, 2005). In addition to the lack of legal and medical protection afforded by a diagnosis, even the declared intention of GID inclusion, the promotion of research, is not met, since in order to be eligible for surgery, transpeople are usually required to receive a diagnosis, and for this to occur, they must describe themselves to providers in a way that makes them fit the diagnostic criteria. This dynamic results in a population that, on paper, seems quite homogenous, a trait that is not an accurate representation of the spectrum of gender identities represented and that is therefore a flawed contribution to any research being done on the community (Spade, 2003).

Jamison Green, a long-time transgender activist, echoes this argument by pointing out the tendency of transpeople to classify themselves as defective or damaged in hopes of receiving one form or another of government aid (which all too often is nonetheless denied). He notes the discrepancy by which transpeople denied medical care available to individuals with other mental illness diagnoses are nonetheless blocked from adopting children because this same 'illness' supposedly makes them unfit parents. He describes the process by which rights and protections of transpeople have been whittled away by legislation pushed

through by Richard Nixon and Jesse Helms, among others, while retaining the stigmas associated with diagnostic labeling. (Green, 1994).

A statement by the International Conference on Transgender Law and Employment Policy acknowledges the reality of a need for some legally recognized means by which transpeople can justify access to hormones and surgeries, while condemning the use of the GID diagnosis, particularly as a method of singling out 'pre-homosexual' children for corrective treatment. This statement calls for a the transition of transsexualism from a psychiatric to a medical issue, paving the way for the legitimizing of insurance claims and removing the stigma associated with having a mental illness. They advocate legal responsibility and the need for civil rights as a foundation from which reform can follow. They list the failings of the 'disability model,' including the explicit exclusion of persons diagnosed with GID from otherwise comprehensive disability acts, the power invested in authorities who often have ulterior motives (using the example of prison doctors, who have been known to 'treat' transgendered inmates by reversing their hormone treatments), and the rights denied to transpeople on account of their mental disabilities (regardless of the fact that these same 'disabilities' do not result in any beneficial protections). Finally, they point out the successes of anti-discrimination programs in ensuring

equal access to public services that no diagnosis has yet been able to provide (Frye & Minter, 1996).

In spite of increasing outcry against the continued inclusion of GID as a diagnosis in the DSM, it currently stands as a reality that clinicians as well as clients must face when working with transgendered individuals. Recent articles have begun to reframe the issue of pathology, suggesting guidelines by which clinicians can treat their gender non-conforming clients respectfully and affirmingly while still working under the limitations imposed by the SOC. Bockting, Knudson and Goldberg in particular lay out detailed suggestions regarding assessment of clients seeking hormones or surgical intervention. They, too, echo Mallon's statement by writing that

> many transgender individuals and loved ones have had negative experiences with health and social service professionals, and may be wary of entering unreservedly into a relationship with the clinician. This is particularly true when the interaction is mandated – for example, as part of obtaining access to hormone therapy or surgery(Bockting, Knudson & Goldberg, 2006, p. 37).

They note that research on transgender communities is still "in its infancy" and that there is much to learn, but proceed to lay out a list of topics with which clinicians would do well to become familiar before beginning work with this population.

The article's optimistic assertion that "there is no right or wrong way to manage one's identity" (Bockting, et al, 2006, p. 47) is dampened somewhat by the realities of a medical establishment in which mental health services play a significant part. A 2007 article suggests that animosity towards trans people tends to originate not from medical professionals but from the larger insurance companies that systematically deny them coverage as a matter of policy. Considering the fact that "individuals who deviate from cultural norms are typically perceived as less deserving of quality care," the article states, it is hardly surprising that many trans people are wary or mistrustful of the medical establishment. The discrepancies, after all, are glaring;

> the client often perceives the [SOC] evaluation…as a hoop that must be jumped through…a type of institutionalized oppression…as a mental health evaluation is not required for non-transgender individuals requesting hormones, breast augmentation, or hysterectomy (Bockting et al, 2006, p. 51).

Given the hurdles faced by transgender clients seeking mental health care, it would seem that clinicians who wish to provide a safe and affirming environment have their work cut out for them. This does not mean, however, that none are trying. Recent research has undertaken the task of preliminary exploration of clinician strategies and interventions that have been more or less helpful in treating LGBT clients in general, and transgender clients specifically

(Israel et al, 2006, Hill, 2005, Hines, 2007, Burdge, 2007). What is striking, however, about these articles is that almost without exception their findings are based upon clinician's impressions of the therapeutic rapport, the success of a particular course of treatment, or the level of functioning of clients before and after therapy. The absence of the voices of the clients themselves is problematic particularly when the goal of research is empowerment and sensitivity. This is noted in one article which states that "often what researchers want to study may not always be in the best interest of the trans communities studied" (Hill, 2005, p. 102). The goal of research, the author states, should be first and foremost the empowerment of the population studied; otherwise, researchers run the risk of irrelevance. Rather than searching for the etiology of gender non-conformity, the article argues, "shouldn't researchers focus on the main obstacles to living a trans life?" (Hill, 2005, p. 104).

It is in answer to this question, in part, that I begin my research with the voices of clients who have traditionally been collectively disenfranchised from the conversation that surrounds their care. Without direct inquiry, it is impossible to know what deficits and strengths transgender and genderqueer clients may perceive in the mental health systems they have encountered, what questions are not being asked. It is my hope that this project will provide the

opening to a conversation that is long overdue and make space for transpeople to take a seat at the table to contribute to the clinical assessment of their lives.

CHAPTER III

METHODOLOGY

This study, which investigates the experiences of trans and genderqueer clients within the mental health system, utilized a design that was qualitative and exploratory. Although there has been a significant amount of literature devoted to the discussion of trans identities and treatment standards, and the voices of trans people themselves have begun to provide some firsthand understanding of trans experiences in recent years, there has been a paucity of literature that deals specifically with trans people's experiences with their mental health practitioners from the perspective of the clients themselves. This study has been designed to address this discrepancy by allowing trans and genderqueer individuals to provide their own narratives around their experiences in therapy. A qualitative design was indicated by the relatively small number of participants in this study (n=12) as well as the relatively unstructured method of gathering data (Anastas, 1999). Due to the fact that this study involves members of a population who have historically been subject to

pathologizing, open-ended questions (as part of a semi-structured interview) were important in order to allow participants to truly speak for themselves, rather than being pushed into limited categories of response.

This chapter will present the methods of research that were used in this study and will describe and explain sample selection, data collection, and data analysis procedures.

Sample

Inclusion criteria for this study were as follows: Participation was limited to adults (18 years of age and older) capable of giving consent who currently identify as transgender, transsexual, genderqueer, or feel that their gender is non-normative in some way. Participants must have spent some time in therapy as a trans/genderqueer person and must be willing to sit for an interview of roughly an hour's length. As a result of this researcher's limitations, all potential participants needed to be English-speaking.

Given the flexible methods used in this study, the result was a non-probability sample of convenience. Recruitment entailed the posting of flyers to appropriate locations (queer listserves and message boards, event walls at local colleges, queer social spaces and health clinics), then expanded to snowball sampling and word-of-mouth. Recruitment was done throughout Western

Massachusetts and Southern Vermont/New Hampshire. Although an original plan included further flyer distribution in New York, New York and Baltimore, Maryland, sufficient participants were found through the initial postings, and further recruitment proved to be unnecessary.

Data Collection

Data for this study was collected through one-on-one interviews conducted at semi-private locations mutually agreed upon by researcher and participant. Once they had contacted the researcher and expressed interest in the study, potential participants were provided with a set of screening questions via email in order to determine eligibility (see Appendix B). The design of the study was reviewed and approved by the Smith College School for Social Work Human Subjects Review Board (see Appendix A), indicating its compliance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. Before beginning an interview, each participant was presented with an informed consent form (see Appendix C) detailing potential risks and benefits of their participation and outlining the nature of their participation as well as their rights as human subjects. After signing this consent form, participants were presented with a list of local resources (see Appendix D), should they wish to seek additional support after the conclusion of the interview.

In order to protect participant confidentiality, signed copies of informed consent forms will be stored in a secure location separate from all audio recorded and transcribed material for three years following the conclusion of this study, as mandated by Federal law.

The interviews, which were semi-structured in nature and lasted between 30 and 75 minutes, consisted of 26 questions (with follow-up or clarifying questions asked as needed) that focused on 1) individuals' gender identity and gender identity development and 2) individuals' experiences in therapy, and the ways in which they have felt that their gender identity has affected quality of care in therapeutic situations. The semi-structured interview and open-ended questions were deemed appropriate for this study because of their propensity for allowing the sort of rich, narrative data that can help illuminate a heretofore understudied topic or population, or a relatively unknown phenomenon (Anastas, 1999). In this case, there is little existing data concerning transpeople's subjective experiences in therapy, and so it was important to present an interview format that allowed for a full range of ideas and self-expression.

The interview guide for this study (see Appendix E) began with demographic questions and included inquiry into the following themes: 1) gender identity and its development, 2) congruence of internal identity and

external presentation, 3) experiences in therapy, 4) feelings about interactions in therapy that involved gender or gender identity, and 5) feelings about standards of care criteria (i.e. gender identity as a diagnosis in the DSM and the mandated process of therapists' letters as a prerequisite for surgery). Each interview was audio recorded on a digital device and transcribed by this researcher at a later date, with all identifying information removed from the written transcription. The interviews themselves took place between February 14 and April 29, 2009.

Data Analysis

Data gathered from the interviews was coded thematically, with a methodical flagging of often-repeated words, phrases, or concepts. Data was then recategorized by theme for the purpose of ease of access during the formulation of the findings portion of this study.

This study had several limitations. The small sample size limits the transferability of findings to a larger population and reduces the capacity for generalization. Additionally, racial and economic diversity was limited within the given sample, so the results reflect the experiences of a group that is largely White and middle class. Finally, since most participants were recruited from

within a small, socially and politically liberal area, their experiences may not reflect those of individuals from less tolerant communities.

CHAPTER IV

FINDINGS

This purpose of this study is to provide an initial exploration into the experiences of transgender/gender non-conforming clients within the mental health system. Qualitative interviews will lend insight into participants' perceptions of the ways in which their gender identities impact these experiences. This chapter will present data gathered from twelve interviews with participants who identify as transgender/genderqueer and will discuss the themes and trends that emerged in their answers to the questions presented to them. (The interview itself consisted of 23 questions that addressed participants' gender identity and its development as well as the content and perceived quality of their experiences in therapy. Each recorded interview was transcribed and participants' responses coded into major themes, some of which correlated directly to questions asked and some of which emerged spontaneously from the participants' narratives. In addition, basic demographic data was collected.) This all goes in your method section.

The findings presented in this paper will be broken down into the following sections: 1) demographic information, 2) participants' gender identity and gender identity development, 3) the ways in which participants' genders effect their everyday lives, 4) discrimination faced by participants as a result of gender identity or gender presentation, 5) participants' experiences in therapy, 6) participants' feelings about the gatekeeping role played by therapists with regard to letters and other documentation, 7) factors that helped participants to feel comfortable with their therapists, 8) factors that caused participants to feel uncomfortable in therapy or to terminate therapy all together, 9) issues with agency settings, and 10) participants' feelings about the inclusion of gender identity disorder as a diagnosis in the Diagnostic and Statistical Manual (DSM).

Demographic Data

Of the twelve individuals who participated in this project, seven identified as White or Caucasian. One identified as Italian-American, one as Mexican/Italian/Irish, one as Serbian/German/Irish, and one as Hispanic/Latino, and one participant declined to provide a racial/ethnic identity. Additionally, two participants listed 'Jewish' as an ethnic identity. Participants ranged in age from 21 to 56, with a median age of 34. All twelve participants had some degree

of higher education; three are currently enrolled in undergraduate programs, four have completed bachelors' degrees, two have either completed or are completing a master's degree, one has completed a doctorate, and two have received other professional degrees.

Participants represented a range of gender identities, and described these identities using the following terms: Female (n=2), male (n=2), trans (n=2), FtM (n=2), transguy (n=1), transgender (n=3), transdyke (n=1), genderqueer (n=3), transsexual (n=2), and transman (n=1). In addition, when asked to describe their sexual orientation, two participants identified as pansexual, two as lesbian, four as queer, one as gay, two as straight or heterosexual, and one as bisexual. However, eight participants stated that their sexual orientation ideally needed more qualification than was permitted in a one or two-word answer. Five participants specifically stated that they felt that the existing categories were not sufficiently accurate descriptions or failed to account for their queer bodies.

Gender Identity and Development

Participants in this study attached a range of meanings to their individual gender identities. Four participants stated that their trans identities remain a crucial part of their self-concepts. Conversely, three participants specifically

stated that being transgender or genderqueer is not currently a major factor in their identities. Additionally, three participants made the comment that their gender identities are defined at this point largely by what they know they are *not*.

Several themes emerged in participants' descriptions of their gender identity development. Six participants noted that, although they felt in some way alienated from their assigned gender, they lacked the language to positively define their identities until adulthood or late adolescence. One participant speaks of her process of acquiring the language to describe her experience: "I know some people are against putting labels and whatnot, but I think identification, it is part of the process. Because once I finally did say to myself, 'Yes, I am transgender,' um, it helped a bit. It really did. Just to identify that."

Ten out of twelve participants stated that they experienced feelings of dissonance or difference beginning in childhood; in many cases, these feelings created a negative impact on participants' self-esteem: "I wasn't good at being a boy," one person recalls, "so I always figured there was something wrong with me…only the part of me that could deal with being a boy stayed around, so I became very shy." Another participant says, "I knew something was wrong once they made me start wearing dresses, and that's when…I think I kind of call

that the time when I started being depressed. You know - five years old, it's kind of like this cloud just kind of came over my life."

A growing sense of desperation with the expectations involved in living with one's assigned gender emerged as another common theme; several participants (n=4) spoke of reaching a 'do-or-die' point at which the cost of 'fitting in' was outweighed by the misery involved in doing so. "I needed to be me," one woman stated, "and if I wasn't, then I wasn't going to be around."

The acquisition of the concepts, language, and terminology that opened up the option of transition occurred for seven participants during their college years. Four people specifically cited meeting another trans person as a formative event that helped them to recognize the existence of alternate possibilities. In addition, three people mentioned some degree of privilege (educational, socioeconomic, or racial) that they felt provided them with access to information and/or opportunity that would otherwise have been less accessible. With the exception of one participant who began transition after a psychotic break during which she began to perceive herself as female, all of the people interviewed describe a fairly gradual process towards their current identities. Three participants specifically mentioned periods of time leading up to transition in which, for a variety of reasons, they made an active effort to conform to the

expectations of their assigned genders. "A lot of transgendered people…we go through these phases of trying to butch it up or femme it up to stay with your birth gender," one participant explained. "I just wanted to fit in," another recalled. "I didn't want to be reprimanded for being different."

The Effect of Gender Identity on Everyday Life

The question of the effect of gender on participants' everyday lives elicited a wide range of responses. One question addressed the degree to which respondents felt their internal gender identities were consistent with external presentation. Six people felt confident that the way that others see them matches how they feel inside. Five people gave a mixed answer; several stated that their confidence in this congruence varies by the day, while others pointed out that they do not really know what others may see or perceive. Only one participant felt that his internal sense of self was consistently poorly matched with others' perceptions of him. Two participants stated that a primary goal is not standing out. "I would like to walk through the world for twenty-four hours and not have to think about my gender and what that means to other people," stated one, "because my gender has nothing to do with other people." Another described her feelings as follows:

> 99% of the time, [strangers] perceive me as me. And that's all I want. I don't want to stand out in society. I don't want to be flashy, flamboyant. I want to be accepted for the woman that I am, the one I've always known myself to be. Just…kind of another face in the crowd.

Others (n=3) noted that, although they are consistently read by strangers in a manner consistent with their identities, they have had to adjust to a new kind of invisibility. "I think [before physically transitioning] there was more complexity than other people saw," one man points out, "although, you know, my own sort of gender transgression or whatever was much more visible in some ways then – in a lot of ways then – than it is now." For transpeople who were queer-identified before transitioning, navigating one's relationship to queerness can, it seems, be complicated by the physical changes that accompany surgery and hormones.

When asked about the fluidity of their gender identities, participants were equally split, with six describing their identities as somewhat fluid and six defining them as more consistent and fixed. This divide was diminished somewhat with regards to outward gender presentation, as eight participants felt their gender presentation was consistent regardless of the circumstance or situation. The remaining four respondents felt that they did alter their gender presentation to some degree depending on the circumstance. Among those who

gave the latter response, this fluidity of gender presentation was attributed to the expectations of others (family members, employers) in certain situations (n=2) as well as to personal preference (n=2). All four, however, noted that they feel most authentic around close friends with whom they can be fully themselves. One respondent gave the following example:

> I do find that when I'm in a place where people might not know I am trans, that I'll try and, you know, 'butch it up' a little bit more, you know? Like, the voice will go deeper, and the mannerisms will be more masculine…And then with my friends I might be a bit more willing to be a little bit more flamboyant…I feel like that's a little bit of a comfort.

Some situations were mentioned more often than others as places in which participants were most aware of their genders. Of these, bathrooms were the most commonly cited environments (n=8), with similarly gender-divided spaces such as locker rooms (n=4) and doctors' waiting rooms (n=5) emerging as strong secondary themes. Those who have not disclosed their trans/genderqueer identities often experience difficult moments at work, as they censor their conversations with co-workers or manage anxiety that body language or behaviors will inadvertently 'out' them. One man describes feeling uncomfortable using the bathroom at work, and so he leaves his office building to use facilities across the street.

For those who transitioned on the job, a new set of issues emerges. As one woman stated,

> As [an employee in] Sales and Customer Service, I used to do some trade shows for work, and I stopped doing trade shows, and some of that I think was…I'm a great representative of the company, but when you've been on hormones for six months, you're hard to peg. Now I've pretty much…people get the right pronouns, but there is definitely an in-between stage where they don't want…You're not fit for public consumption from a business stand point, or so they think.

Another man spoke of professional contacts who stopped returning his messages after learning of his transition. He speaks to the invasion of privacy that comes with transitioning on the job:

> I had to come out at work, and so I don't know who knows and who doesn't, and so that's a little bit weird, and, you know, sometimes people still make mistakes, so I feel like it, you know, once you bring it to work…I'm an intensely personal person…I like to keep my private life private. And so to have to bring this super intense thing to work…This is about ownership, you know? This…this is mine…But it isn't like that. People feel like it's part of their lives now because somehow they're involved and affected by it…I can't tell whether my interactions are based on, you know, just me and who I am or…things they've heard and gossip, and things like that, so it does feel a little bit like it's more a part of my job than I would like at this point.

A third participant acknowledges both the privileges that come with taking on a White male identity and the limitations imposed as a result of being transgender:

> There is such a difference in the way I'm just perceived and treated. I put a lot less energy into worrying and wondering and feeling angry about being misperceived and stuff like that than I used to before…You know, privilege is real. The White male privilege thing is very real. I knew it before. I certainly know it now…[However,] being a priest and being a transman I find that it's hard. I know that my bishop would not seek to deploy me in most places. There's a sense of limitation there.

For several participants (n=5), their gender identity informs their work in a significant way, prompting a decision to choose a career path that allows them to give back to their communities. Three people are active educators around gender issues and three speak of choosing their professions at least in part because they will be able to provide services in fields that have often been sources of discrimination for trans or gender non-conforming people in the past. "I'm not sure if it would be different or not if our world was different and I totally had…rights to everything," one respondent acknowledges. "If that were true, would I want to be out as a trans person? I don't know. But because of the way that our world unfortunately works, I don't have a whole lot of rights, and so I'm stepping out there and doing that." Another, who works in the medical field, states:

> I've had prospective employers that will ask me, you know, what's your favorite kind of patient, and for years I've done the "oh, I like all my patients," answer that I think they want to hear, but… I just want to tell them: My favorite group of people to take care of is the LGBT community. Because of, you know, the problems a lot of them have had and, again, the real or perceived prejudices in health care and medical care and stuff…you know, I will ask for every gay, lesbian, bisexual and transgendered patient that walks through the door, because I know I'm not going to be prejudiced against them.

Discrimination

All but one of the participants in this study reported having experienced some degree of discrimination as a result of gender identity or presentation. These experiences ranged from overt (physical violence, expulsion from places of business, loss of employment or demotion, verbal attacks) to subtler aggressions (deliberate use of incorrect pronouns, questions in restrooms, disapproving looks). Five participants remarked that they felt fortunate because they believed they had suffered less overall discrimination than many other trans or genderqueer people. Five people also expressed a belief that living in a relatively liberal area has reduced incidents of discrimination. "I think this is a little bit of a bubble," one man pointed out, "even though [being trans] is still difficult because it's so different." Five of those interviewed said that they were discriminated against more frequently before transition or while they still appeared more ambiguously gendered.

Participants in this study shared various strategies for avoiding and combating these negative and dangerous experiences. Four people said that they avoid places or activities in which they feel they are likely to be discriminated against. "I don't go out too much," one woman explains. "What I'm saying is that people don't have the opportunity to be jerks to me." Another person specifies, "I avoid situations where I assume I would be discriminated against, like corporate job interviews where I assume appearing as myself would make me ineligible for being employed."

Other coping strategies included reframing negative experiences as testaments to personal strength (n=2), choosing to ignore looks and comments (n=1) and entering situations with the expectation of respect. One man, who states he has dealt with a fair amount of discrimination in his life, shares:

> Every time I come out of one of those situations I say 'I'm stronger for it. And, you know, I fought for myself and I won, because I'm still here and I'm still alive and I'm not gonna hide who I am because someone else doesn't like it.'

Another participant, who says she feels she has for the most part avoided discrimination, says:

> I am of the tentative belief that a large amount of how an interaction will go will depend upon the attitude that you enter it with, and because I've been…spoiled, you could say…I never…enter situations expecting discrimination based on gender.

Experiences in Therapy

Though all had previous experiences being in psychotherapy, participants in this study represented a range in terms of amount of time spent in treatment, as well as the number of therapists and quality of experiences reported. The age at which participants first saw a therapist ranged from ten to forty-four, with a median age of eighteen. They have each spent between two and thirty-five years in therapy and have seen anywhere from two therapists to "too many to count." The majority of participants (n=8) began seeing therapists in college; three began therapy in childhood or early adolescence and one began later in life. Initial reasons for seeking therapy also varied; only three participants listed gender identity issues as a primary motivation (although for all twelve, gender identity did at some point become a topic of conversation). Additional reasons include depression, family issues, anger management, alcohol use, anxiety, self injury, and suicidality.

When asked to describe their experiences in therapy, participants repeatedly returned to several common themes. Eight participants reported at

least one therapist about whom they felt "very positive." The remaining four participants all reported at least one experience that was "pretty good." Eight participants have had therapists or experiences in therapy that they categorized as either somewhat negative or extremely negative. For several people (n=7), the quality of the therapeutic relationship shifted from negative to positive once they were in a position to self-advocate and seek out affirmative care. One woman recalls an early experience with a Christian therapist who pushed her to maintain behaviors appropriate to her assigned gender:

> I said, "you know, this just ain't working. I've read your books, and you know, I've read the Bible – I've read two different Bibles – and you know, this stuff's still there." By the time I started transitioning, I became an informed consumer.

Her decision to begin to seek out care based on therapist expertise is echoed in the comments of others. One man explains that he feels the quality of care that he first received was compromised because "early on I didn't know to ask for or to request someone who had a gender specialty. So some of the therapists I was seeing, through no fault of their own, just really couldn't help me too much." Another man preemptively addressed this dynamic through pro-active research: "I chose someone who was a gender specialist," he shared. "And

then I knew when I was ready if I wanted to I could go there as far as the gender stuff was concerned. And I did."

In spite of efforts to seek out gender specialists, the majority of respondents (n=8) mentioned that they had at some point found themselves in the role of educator regarding gender identity issues in therapy. They expressed a range of feelings – from uncomfortable to okay to weird – about this role, and perceived variable willingness on the parts of their respective therapists to be open to further education. "I found that therapists were pretty open to educating themselves once they understood that it was an issue that they were being called to be informed about," one participant offered. She felt that she has been compelled to offer some of this education, but "no more so than I would with the average layman." A second participant spoke with some frustration of resistance ze had encountered in encouraging therapists to further their education:

> I think that people think they know, or they've read enough, or, I mean, my assumption is it's threatening…because working with transpeople and being around transpeople brings out people's gender issues…There are these two boxes that you can be in and you get forced into them from birth, which is very traumatic for a lot of people, and people don't want to deal with that trauma and don't want to admit that it's there and don't want to deal with the fact that we live in a patriarchal culture that is set up so that there are two genders and one dominates the other, and it's woven into every fabric [of society]…So the second therapist I worked with, I talked with her about that and she said "Oh, I'm clear about my gender

> identity. I don't need to go to those things." Which to me is saying exactly the opposite, is saying "I am scared of my gender identity, so I won't go near one of those things."…Therapists I've worked with, I've yet to convince one of them to go to a gender conference.

Several participants (n=5) expressed feelings that were neutral or positive about providing education to their therapists. "I feel like I've taught them a lot," one woman states. Another man notes that "it shows me that [the therapist] is interested in learning more, and interested in what I'm going through, so that's been positive." Those who responded negatively to taking on this role often felt that their therapists had a responsibility to educate themselves before taking on trans or genderqueer clients. "The point is that they need to know transpeople," one person states, then elaborates:

> I don't think that should be in a therapy setting…You don't know how to use the language unless you…have been privy to that kind of experience. But I don't think going into an online forum is going to do it either, because most trans guys don't want a therapist in their online forum…So I think limiting it to conferences and things like that, where people are ready to teach and be taught. You know, and you can learn that way instead of at the expense of other people.

Several others also addressed the question of education, suggesting ways that therapists could seek further information without invading trans spaces in an inappropriate manner. These suggestions included: Reading books by trans people, reading books by the partners of trans people, inviting trans speakers,

attending conferences, consulting with other therapists who specialize in trans issues, attending workshops, and looking for online resources. There was some ambivalence between participants surrounding some of these issues; while the idea of attending conferences, for example, was widely supported, there were those who felt that doing so could diminish important spaces in which trans people are specifically *not* responsible for educating those outside their communities. Additionally, one participant was wary of recommending books by trans authors to therapists because he felt their accounts were less objective than books by the partners or children of trans people.

Therapist as Gatekeeper

Transpeople who wish to begin taking hormones or have surgery to further their physical transitions are often required to obtain one or more letters from one or more therapists, stating that they are of sound mental health and capable of making these decisions for themselves. The necessity of this letter puts therapists of transpeople in a gatekeeper role that may complicate the therapeutic relationship. This gatekeeping role elicited strong reactions from many of the participants in this study, ten of whom have themselves gone through the process of pursuing such a letter and one of whom is about to reach

that point. Although the majority of participants (n=7) believe that it is important to have in place a system to make sure that surgical candidates are adequately supported, all but one person (n=11) expressed some degree of negative feeling about the current system, and many spoke at length about their concerns. Two respondents reported experiences in which they felt mislead by their therapists. They told stories of being strung along with promises of a letter that was later denied for what seemed to be arbitrary reasons. "People are really abused," one person states, then goes on to describe what he and his friends have found to be a common experience:

> You know: "I'll write you a letter in three months. Oh, you're not ready yet. I'll write you a letter in six months." You know, "and that's four thousand dollars, by the way." They just wany to keep you in therapy and make their money…Informed consent is informed consent, and that's what I believe in. But I think a lot of therapists do not. By any means.

Another young man speaks about a frustrating experience in which his therapist abruptly decided to change her mind about writing him a letter. She terminated treatment without providing any explanation, leaving him to start the lengthy process over again:

> [My therapist] kept on telling me, you know, "I'll write you a letter, I'll write you a letter, I'll write you a letter by the end of our, you know, the time that we spend together. I think that you're where you really need to be, but we really need to be spending some time together following, like, the Harry Benjamin Standards of Care, and, you know…doing everything

> legal. And I was feeling really positive about that…You know, I was like, ready to go, and I was probably 20 or 21 at that point and I was so excited about it, and then one day she came in and she said to me that she wasn't gonna write me a letter…that she just kind of changed her mind…which really didn't make sense, and she didn't do a lot of explaining as to why she wasn't going to do that…I was like 'I don't understand; why have I spent, like, the last however many months with you? Why all of a sudden are you just like throwing all of this work away?' Because for me, the entire reason I was there was for that letter, you know? I've been yanked around, and that made me really afraid to go back into therapy…I see it as a stupid gateway, definitely. I think it's really silly that someone has to tell you who you are.

The idea that a professional is mandated to make decisions about a client's body struck several people (n=4) as a clear injustice. One person pointed out the hypocrisy she saw in this selective requirement: "You can get a boob job, just get your boobs bigger or reduced, and you can get implants in your calves for bigger muscles or pec muscle implants without having to have [a letter]. It's not fair. It's probably discriminatory…You should be able to do with your body what you want as long as it's not hurting anybody else."

Another theme that was nearly universal among respondents was that of honesty. Nine participants stated that they felt the gatekeeping role interferes with the honesty of the therapeutic relationship, and many had adamant feelings on the subject. "It's this peculiar thing," one person comments,

> …where you want to be in therapy and therapy's the one place where you want to be totally honest with the person if you want to get real help, and there's so much incentive not to be honest if you want to get the letter, to say what you need to say to get the letter. The stereotype that I have in mind is the person who's really in some way gender-variant and knows that if they want to get the letter, they've got to say 'I've always felt like a little girl, ever since I was two…' because people know that's what they're supposed to say…I don't think I've ever talked to a single person who went through that process and would honestly say that they were honest in the process.

Connected to the notion that trans people, through the process of transitioning, often become astutely informed consumers is the idea that, having learned what it is that they must say in order to get the letter, clients will sacrifice an authentic therapeutic process in favor of rote answers they know will get them the documents they need. Thus, the process itself becomes a farce as more false narratives are added to existing research, affirming the very falsehoods that drive the existing protocols. "It's encouraging not being perfectly honest," one respondent explains. "It treats you like a kid, like you were when you were twelve, and if I say the right thing I get the cookie, and if I don't say the right thing I get in trouble, so you say the right thing." One participant, who described himself as having mixed feelings about the letter requirements, felt that while it is good to have a support system in place, that system is currently broken. He described the dilemma as follows:

> The problem is that because it's a gatekeeper system, people play it. You know, you want to trust [therapists], and I feel like having this whole gatekeeper thing makes you not want to trust somebody, because if they have that much power over your future, you just want to play it straight…I don't see the point…of having this one person who's met you…for three months, maybe seen you six times, having that much power over your life.
> .

It is not simply the incentive to be dishonest that bothered the participants. The narrative in which they felt compelled to participate in order to receive their letters felt problematic to many. One man, who does not necessarily disagree with the concept of some sort of gatekeeper role, spoke to the problematic elements of the standards of care that inform that role. "To me, it felt like [the Harry Benjamin Standards of Care] were mandating a certain kind of gender conformity…It felt like there was a danger of creating…normative channels of gender or participating in already existing ones." Another person echoes this sentiment:

> The whole narrative is really injurious to what transgender actually is…to spout the stories [that are expected in order to get the letter] I think probably undermines the queerness that's often inherent in non-normative gender.

Positives in Therapy

Participants in this study were asked what about their own experiences in therapy has made them feel safe and respected. They were also asked what they feel are the most important things a therapist can do in general to foster an affirming atmosphere. Although responses were varied, a number of patterns emerged. Most notable among these were: 1) a willingness to learn, 2) an openness to possibilities/absence of agenda, 3) a knowledge of the trans community, 4) comfort and familiarity with affirming language and terminology, 5) respect for chosen names and pronouns and 6) an approach that is more warm and casual than cold and clinical. In addition, three participants stated that they specifically prefer therapists who themselves are part of the queer community, because this gives them confidence that the therapist will see them as an equal rather than an 'other.'

Seven of the participants interviewed cited willingness to learn as an important attribute for a therapist working with trans clients, though several specified that this learning needs to be done outside of the therapy session itself. Specifically, the need not just for initial education but for ongoing learning was a topic that arose more than once (n=3):

> There definitely needs to be more education around it initially, and past that…Identity is constantly changing. New words are coming out. New concepts. And I think that, you know, someone who is trained on trans stuff in 1973 is totally not going to understand what it means to be trans in 2009.

Six people stressed the importance of openness to possibilities, the acceptance of each client's individual process and the absence of an agenda. When asked what he appreciated about his therapist, one participant replied

> She never forced me to…like, she wasn't like 'oh, you should start hormones now. Isn't it time for top surgery?' It was all initiated by me…Which was good, because you should go at your own pace, which should be what you want and not necessarily what she thinks or what she wants….So, yeah, everything was self-initiated.

In connection with this idea of viewing the client as an individual, one participant raised the point that "we're all coming from different places. Because obviously I've gotten huge support. I can't imagine not having all that support. But there are plenty of people out there who are getting, you know, kicked out of their homes, and they're gonna need a lot more than I do." Another participant echoes this thought with "No trans person identifies the same, so you can't apply one set of rules to them." He continues:

> I think the mistake that people make is that everyone wants the letter and everyone wants the hormones, and not everybody does. And some people do, and that's all they want, and both of those are okay.

Another participant who put 'don't assume anything' at the top of her list gave an example of the discomfort caused by this often well-intentioned assumption:

> The first person who I saw outside of college as I was trans didn't have any experience and at that point was assuming that I was having surgery and I was assuming I wasn't, and was assuming pronouns before I was necessarily okay with that…She was rolling out 'she' before I was ready for it…Everyone's experience is entirely different. You can make some pretty broad assumptions and be right 90% of the time, but the other 10% of the time you're gonna alienate a client and lose somebody. And that's not cool.

For several participants (n=4), an established knowledge of the trans community and connection to other resources was a major factor that led them to choose a particular therapist and was as frequently cited as a factor that made them feel at ease and cared for. One woman describes the things she values most about her current therapist, who is herself a transwoman:

> Having actually gone through it to know the feelings and know what you're describing I think does make a difference. Um, and the fact that she was involved with those professional societies, involved in, you know, the transgender standards and such, you know, has made a big difference.

> And she has lots of resources and can tell you where to go and knows a lot of stuff in the community.

In addition to a general knowledge of resources and local communities, an awareness of current language and terminology was a factor that made a significant difference in participants' comfort in therapy. One respondent talks about finding a therapist he felt comfortable with after a string of professionals with whom he felt he couldn't be completely honest: "I think also part of the reason I didn't lie to him was because he knew what I was talking about, you know, when I use certain vernacular about the trans community." This comfortable use of language was mentioned several times as a strong indicator that a therapist can be trusted. Says another participant:

> She…flawlessly transitioned to the 'he' and 'Emmanuel[2].' And without any… there was no pre-emptive 'oh, I'm sorry if I make a mistake' or 'I apologize in advance.' No, it was just "Emmanuel." And it's amazing; that was great. You know, it was the easiest one, out of everybody. So yeah, I think that really made an impact on me, that there was no…it was like 'oh, of course this is what's happening. Okay.' And, like, she knew it was going to happen and there was no explanation for it. That was just the way it was.

This statement brings up the additional point of comfort with chosen names and pronouns, a factor which was seen by many participants as a basic

[2] Name has been changed.

point of respect. One participant, who uses gender-neutral pronouns, stated that the most salient factor in assessing hir comfort with a therapist is whether that therapist is "ostensibly willing to use the pronoun and…read the information that I give them." Another person describes his reaction to a therapist who specifically made sure that his chart and files reflected his chosen (rather than legal) name, and that all staff in the clinic were aware of his preference:

> Every time someone does that for me, it makes me want to just sit there and praise them…because the fact that they took five seconds – literally, five seconds to write down my name – just makes the biggest world of difference, you know?

In addition to trans-specific factors that these positive therapy interactions shared, many participants in this study cited more universal factors as well. A therapist's overall manner and personality were, for some people, as important as her/hir/his familiarity with trans people as clients. The provision of a warm, casual atmosphere, a laid-back approach to therapy, a good connection or rapport, a respectful environment, solid ethics, good listening skills, stability, honesty, and a balance between validating and challenging were all examples given of professional characteristics that made participants likely to continue seeing a given therapist.

Negatives in Therapy

Not surprisingly, there was a good deal of overlap between the positives that participants identified in their experiences in therapy and the negative traits or behaviors coming from their therapists that made them feel alienated, unsafe, or just uncomfortable. The most commonly cited experiences were as follows: 1) therapists who push in a particular direction, 2) therapists who do not admit to a lack of knowledge, 3) therapists who lack experience working with trans clients, and 4) therapists who are pathologizing or condescending. In addition, two participants spoke of therapists who displayed poor boundaries or other unethical behaviors (befriending or dating clients, sharing very personal information, taking phone calls or eating meals during sessions).

The most commonly cited factor (n=11) was a feeling of being pushed in a particular direction by a therapist. For two participants, this involved a therapist who pushed them to accept their assigned gender and associated gender role. More common, though, was to encounter a therapist who pushed a client towards transition when the client may not have felt comfortable with that decision. One participant states that ze dislikes feeling that a therapist is "making assumptions about what my process as a transgender person is, that it fits into some transition from one to the other." Another echoes "I think

[therapists] assume people want to transition too soon." "It always comes down to the same thing," one person comments. "That everyone's different. People are who they say they are. I mean, I know that's a tricky thing for therapists, because a therapist is supposed to be some kind of authority who in some way knows better, but…it's really important to accept who people say they are in terms of gender."

Concern about this 'therapist-as-authority' stance led several participants to specifically seek out therapists who did *not* profess trans expertise. "I sort of didn't want somebody who had trans experience because I feel like sometimes you can maybe be swayed one way or the other," one man noted. "The thing I was most concerned about," another adds, "was not feeling like I was being channeled down any particular outcome as far as gender stuff was concerned." Some participants felt that this channeling can arise from the previously-discussed gatekeeper role, and a sense of obligation it engenders:

> There's a feeling that things need to be done a certain way, that there's…one process that every trans person goes through…and that it needs to be precise and exact and that…they are the gatekeeper and somehow hold some type of authority over you in certain situations. I think that would turn me right away.

One participant pointed out that this mentality is to some degree the result of a larger system, rather than an indicator of therapists' prejudices:

> There's like a checklist. Okay, the letter, right? The letter has to show that this person has had discomfort with being, uh, the sex that they were assigned at birth, and, like, they dressed as the opposite gender, and there's a feeling that those things are just checklists, and that bothers me that that may be the only access to information that [therapists] have. You know, 'this is what you need to get the letter, so this is what you need to ask, and this is what you need to deal with,' you know? 'These are the questions.' But again, it's not their fault, 'cause these are the standards that are given to clinicians.

In addition to pushing too fast or seeking to influence the course of their clients' processes to an uncomfortable degree, several participants (n=3) cited an unwillingness to admit a lack of knowledge as a major roadblock to effective service. "I think there is a stigma that therapists need to know everything," one participant explains, "and so they try to. "And sometimes they will lie to you in order to do that." A therapist who is willing, however, to admit to a lack of knowledge and seek out the appropriate resources, goes a long way in earning a client's trust. "People need to own if they don't know something," states another respondent. "No one is ever – not one person can, like, embody and know everything there is to know about trans stuff, because from moment to moment it's changing. Just like any identity, you know?" Therefore, while it is quite excusable, he suggests, to be less than well versed in some aspect of trans

awareness, the real problem arises when a therapist feels the need to come off as all-knowing, even at the client's expense.

In contrast, a lack of experience with trans issues was not necessarily experienced as a negative; while three participants did state that they were upset or put off by a therapist's lack of knowledge about trans issues, several more felt that, although their therapists were not particularly informed, a willingness to acknowledge this deficit and to pursue more information was an adequate compensation. These respondents (n=7) generally felt that a therapist's overall attitude and ability to connect was more important than their level of textbook knowledge.

For some participants, the sheer importance of the process of transition necessitated a therapist who was knowledgeable in the field. "I left my last therapist because she didn't have any experience," one person stated bluntly. "Plain and simple. I need that. I want that confidence, you know, that I'm getting the best care, the best ideas, the best…networking. The best of it. Because I want all the angles. This is my life."

For others who found a dearth of education to be a significant issue, a perceived lack of generally required professional education was often more frustrating than an individual therapist's lack of knowledge. "Unfortunately,"

one woman states, "so little seems to be taught to therapists in general, that they know very little or hardly anything at all about the transgender community in particular." She goes on to elaborate upon the impact she believes is a result of this educational deficit:

> I think I have had to take a lot of control for myself and stand up for what I wanted. Unfortunately, in this community, there is a big prejudice, be it real or perceived – maybe it's some of both –from the LGBT community. Because somebody they knew had a bad run-in with a therapist…I know it's changing, and for the better, but I know that a lot of people in the community don't want to seek the care because of the prejudice they have [experienced] or feel they might or might again experience.

This sensitivity towards prejudice is underscored by several respondents' accounts of judgmental treatment received from therapists during their transition process. Specifically, three participants recounted therapists whose attitudes were either generally condescending or particularly pathologizing of their clients' gender identities. "She couldn't help me," one participant said of one of his counselors, "because she didn't see me as an equal." He went on to elaborate: "I don't want to be interesting to you…and not being interesting to somebody is the point." He felt that his gender identity was treated as a novelty for this particular therapist, a fact which bothered him all the more because at that point, gender identity issues were not his primary reason for seeking therapy. Another participant notes that an important step therapists can take in working with

people who are trans or genderqueer is "not to see demons where there aren't demons. Not to interpret confusion as sickness." Another participant was frustrated by a therapist who was not straightforward about the judgments he was making; she felt he found indirect ways to communicate his prejudice:

> [The therapist said] "well, you've got some gender issues here, but I don't think that's really your problem. Um, here, read this book: 'Wild at Heart: How to be a Better Man.'" Obviously you think it is, to an extent, [a problem] if you're giving me specific reading information on how to be a better Christian man.

Overall, participants in this study were very clear about the fact that they are quite aware of the difference between being supported and being cured, and most (n=11) were able to self-advocate sufficiently to keep searching until they found therapists who were able to provide the support that they were looking for.

Agency Settings

While the one-on-one interaction with one's therapist was the primary focus of this thesis, a secondary question addressed the physical environment in which the client was seen. The settings in which the therapy itself took place varied for this study's participants, and ranged from college mental health

settings to private homes that housed private practices to clinics and mental health agencies. Participants were asked to recall both positive and negative experiences in these settings, and to suggest ways in which these spaces can be made more trans-friendly.

Advertisements in papers catering to the LGBT community emerged as an often-cited method of conveying an ability to work within the trans community. Several participants (n=5) stated that they had searched for therapists by looking in such publications and found this to be an effective way of accessing appropriate services. In addition, six people mentioned the waiting room environment, suggesting stickers on the walls, fliers, pamphlets, books, or posters that advertise a commitment to trans-inclusiveness.

Others were less focused on the physical environment, and more concerned with the treatment they would receive. One participant specifically stated that

> I think that when it comes to comfort, rooms don't necessarily …like, the décor doesn't really make a difference. It's more the interactions with the people that's so, you know, having a staff that is respectful and that are not surprised. You know, they're not like "oh, really? Oh, crazy!"

Comprehensive training for all employees of a given agency, including receptionists and other staff, was strongly suggested by several participants (n=4), in order to be able to provide appropriate referrals to potential clients and to avoid stigmatizing or uncomfortable waiting room incidents, particularly involving the use of incorrect pronouns or names. One participant, who ended up leaving one therapist as a result of this discomfort, stated:

> I've just come to expect that [being called by the wrong name in the waiting room] is going to happen, so every time I go to any type of doctor's visit, I expect to be outed, which is really sad. And because of that expectation, I was like "I can't do that. I'm in therapy to make myself feel better. If I feel like crap five seconds before I enter the room, nothing's gonna go well.

Another respondent agrees, and suggests a way in which an agency could work pro-actively to increase the comfort of its gender-variant clients:

> [Being in a waiting room] is always a nerve-wracking experience when you're in the process of transitioning, because, oh god, I think they're gonna yell my old name…and then you're gonna have to get up. And then, you know, that kind of stuff… Those are just horrible nerve-wracking experiences. I don't know how much you can do. I think maybe you should be able to call ahead and say "you know, I'd like you to call me by this name. You know, make sure you call me by this name when you call me in" and have them be respectful of that. I think that would be great.

In addition to clinician/staff sensitivity training, inclusive language on forms, advertisements, and paperwork was cited as an important sign of respect by a number of respondents (n=4). One participant specifically suggested using the phrase "all genders welcome" because, as ze noted, "adding more letters to GLBT doesn't do it, because that's by nature *ex*clusive." Another elaborates on the importance of inclusive language, "If [working with trans people] is really your interest and what you want to work on, I think you need to flag that…because gay and lesbian doesn't mean anything to me. 'Cause there was like a hundred gay and lesbian friendly people [in the advertising section]…That doesn't mean they're trans-friendly." Forms that do not include obligatory male/female boxes and that allow for a variety of gender experiences were also noted by several people (n=3) as important provisions an agency can make to avoid inadvertent discrimination.

Two participants were quick to point out that, regardless of the ways in which an agency advertises, the quality of service that is provided there will speak for itself. "The trans community can be pretty tight," one woman notes, "and there's a tight network. Trans people will note if they've had a good or bad experience with these providers." Agencies that are not comfortable or welcoming will lose clientele, another man points out, because "society will

gossip and teach you things, unfortunately, and that will turn you off to going there."

Gender Identity Disorder in the DSM

A particularly loaded issue for the participants in this study was the question of Gender Identity Disorder (GID) as a diagnosis in the DSM. Many of the respondents had strong feelings about this topic, with six people asserting that it should be removed entirely and four people stating that it needs to be changed so that the diagnosis does not reflect any sort of pathology. Additionally, one person replied with no comment because she didn't feel sufficiently informed on the issue to pass judgment, and one person stated "I don't care what they call me…if it gets my T[estosterone] paid for."

The majority of participants interviewed took issue with the characterization of GID as a psychiatric illness. "I don't see my gender identity as a disease," one person remarked, "and for someone to hold you back because some book that some person…wrote one day said 'this is a disease' – that's enough to kill you." He goes on to question the pathologizing of identity:

> Your identity is not a disease…There are as many identities in this world as there are people. Well, great. Why are some people's identities diseases and some peoples' aren't? Who decided that?…It makes it easier for some people to write it off…even people who wouldn't be against it

> normally, [someone] who's like… "It's a disorder and it's a disease, and I'm going to believe that because I read it in a book."

Another person asserts: "It's not a pathology! It just boils my blood, because it's…just saying 'you're a sick person that needs professional help to get through this.'" He goes on to add that:

> [the guidelines dictating appropriate care] should be written by people the community who are medical professionals within the community. They shouldn't be written by, you know, White old men somewhere. Those are not the people who should be writing this. It's not their community. They're not the ones who have the experience.

Others were more blunt, stating "Of course it shouldn't be there! It's bullshit. It's not a disorder…I think it needs to be out," and "…completely inappropriate. Very insulting…It blows my mind that it's even in there."

For those who desired to see a drastic restructuring of the diagnosis, a common complaint was the suggestion that gender identity disorder indicates a problem within the individual. "I think it can be useful for it to be in there," one participant explains,

> …but it needs to be defined as people suffering from trauma as a result of discrimination based on societal gender norms, or some language like that: it's a particular kind of trauma. It's not a mental disorder in itself, but a particular kind of trauma resulting from a societal structure…a societal structure that traumatizes and discriminates against people who don't fit into that structure…The person is suffering from something

> because they're gender-variant and they're living in a society that doesn't accept gender variance.

Another woman agrees, stating that although it is certainly true that being transgender can be a source of psychological distress, that distress is, in fact, a result of the social environment and the obstacles it creates, and is not inherently pathological:

> It's ridiculous…I mean you can definitely be quasi-dysfunctional or having mental health issues about a disparity between your expression and who you feel you are. That makes sense, but that's also a general malaise kind of deal, and being unhappy about the political situation…[In my case] it wasn't even internal; it was external, it was the other people getting me wrong. I knew what was going on and I was totally okay with it. But I wasn't in a situation where I felt capable of presenting that…It's not mental, it's not a mental illness. It's just…an unfortunate situation.

Two participants used the phrase 'double-edged sword' to describe their assessment of the diagnosis. Regardless of their feelings about the pathologizing influence of a DSM diagnosis, seven of the people interviewed touched upon the issues of insurance coverage and access to care; without a diagnosis to point to, they are concerned that some trans people may be denied necessary services. "Insurance companies need to cover the stuff, you know, flat out," one woman states. "Again, I don't know if it being a classification makes it more likely or less likely for the insurance companies to cover it. You know, they de-classified

homosexuality in I believe the 70's… and it kind of validated a lot of people, you know: 'You're not crazy'." One man is adamant about the fact that "if you get rid of it, a lot of things aren't gonna get paid for." For that reason, he has no particular desire to see the diagnosis removed. At the same time, another participant cautions, "it puts up a lot of barriers…It's pathologizing." Another participant, who had recently attended a workshop underscoring the positive aspects of the diagnosis, added "I think that for some people it's needed to get those letters and to do certain steps in their transition. But unfortunately it also stigmatizes who we are as people."

The findings of this study, reported above, represented diverse viewpoints and experiences. The responses of participants were grouped into ten thematic sections to provide a framework for discussion. The following section will discuss the implications of these results and their relevance to the existing literature and to the social work profession.

CHAPTER V

DISCUSSION

This study has sought to explore through qualitative methods the experiences of transgender/genderqueer clients in therapy, and the perceived effects of their gender identities on quality of care. Within the literature reviewed in relation to this topic, there was seen to be an evolution through the past three decades from articles whose tone was generally pathologizing to those that advocate a more trans-positive, affirming model. However, with a few exceptions, there continues to be a lack of work that reflects the voices and experiences of the clients themselves; the bulk of the existing research devoted to determining appropriate standards of care for people in the trans community has been the domain of non-trans (and largely White male) professionals. This study aims to address this imbalance.

Findings for this study emerged along the following themes: 1) participants' gender identities and relationships to those identities, 2)

participants' experiences in therapy, 3) participants' feelings about therapy, 4) participants' thoughts about the gatekeeping role played by therapists with regard to surgical letters, 5) participants' experiences with playing the role of educator in the therapeutic relationship, and 6) participants' feelings about the inclusion of gender identity disorder as a diagnosis in the DSM. This chapter will relate these findings to the prior writings detailed in the literature review and discuss relevant contrasts and correlations. It will also suggest areas for future research and exploration.

Even in this limited study, the range of ways in which participants conceptualized and defined their gender identities illustrates the problematic nature of the prevailing notion that there is one general treatment framework that can be fitted to all trans people. Several of the participants' assertions that "everyone's experience is entirely different" contraindicates the traditional diagnostic process, which seeks to categorize by similarities rather than allowing for differences. In doing so, they echo the findings of recent researchers (Bockting, Knudson, & Goldberg, 2006), who emphasize the heterogeneity of a population historically portrayed as rigid in its adherence to a narrow set of stereotyped behaviors and ideas. Indeed, the number of terms used by

participants in this study to define their gender identities nearly matches the number of participants themselves.

The earlier articles reviewed for this study, written primarily during the 1960's and 70's, describe their gender-nonconforming patients with a distain that is hardly clinical. Transsexual and transgender individuals are consistently described as narcissistic, delusional, and neurotic, and are often lumped together with 'homosexuals' and 'transvestites.' One study explains that its subjects "showed a marked impairment in their ability to give an adequate history of their past lives." When pressed, they became disturbed by memories of unhappy childhoods. These observations led the researchers to conclude that these women (all of the subjects in question were MtF transsexuals) originally began to envision themselves as girls in an attempt to escape from sordid family circumstances (Socarides, 1969). The idea of transsexualism as a reaction to a childhood marred by abuse and trauma is a common thread that runs throughout the literature and in some cases persists to this day. The findings of this study, however, refute this stereotype; of the twelve people interviewed, only one mentioned abuse. Seven participants spoke specifically of supportive families and mentioned positive childhood experiences. It is also worth noting that all twelve of the individuals interviewed provided articulate and cohesive

narratives of their gender identity development, often describing complicated relationships with their own bodies and senses of self with which they grappled in the absence of language that would describe their feelings.

In summary, then, the sample interviewed for the purposes of this study (though admittedly a rather small one) resoundingly refutes the characterizations put forth in early literature about trans people and their ability to hold accurate self-representations. Fortunately, some later work that has since emerged reflects an effort to view transgender clients as competent people who can accurately perceive the challenges facing them and their options in meeting these challenges. Until a baseline of basic mutual respect is established, it is difficult to envision a therapeutic relationship from which a client could genuinely benefit. This respect, as will be seen below, is only one of several factors identified by participants in this study as determinants of the quality of their experiences in psychotherapy. In their 2006 article, Bockting, Knudson and Goldberg lay out a series of things therapists can do to effectively build a trusting rapport with transgender clients. The findings of this study were consistent with many of these suggestions, including particular care given to the use of a client's preferred name and pronoun, the visible presence of trans-affirming literature in offices and waiting areas, demonstration of knowledge of and sensitivity to

trans-specific issues, and a non-judgmental attitude towards a client's gender presentation and identity. In addition to these, individuals interviewed for this project added a willingness to learn and a warm, casual approach.

Although the mainstream attitudes towards transgender clients as evidenced by the current literature has shifted overall towards a more affirmative model, conspicuously absent is commentary on the things a therapist might intentionally or inadvertently to do alienate a potential client. With several notable exceptions (Zucker & Bradley, 1995), many therapists, particularly those who specialize on work within the trans community, no longer see the prevention of a transsexual outcome as an ideal or even viable solution to resolving a client's gender-related distress. This being the case, the literature, too, has shifted, and now devotes itself less to rooting out pathology and more to finding ways to work effectively and ethically with transgender clients.

However, although there is some acknowledgment of the fact that many trans people may be wary of therapists due to past mistreatment, rarely in the literature are the clients themselves asked for feedback concerning their experiences, nor has there been a comprehensive review of therapist errors in dealing with this population. Participants in this study most frequently listed therapist assumptions or agendas, an unwillingness to admit a lack of

knowledge, a lack of experience with trans clients, and an attitude that is pathologizing and condescending as negative factors they had experienced within therapeutic relationships. Among those who felt they had encountered a therapist who made incorrect assumptions about their identity, the majority indicated their therapists had in some way pressured them to transition before they felt ready. This finding confirms the work of Carroll, Gilroy, and Page (2002), who note that most respondents in a study of MtF women were "pressured [by their therapists] to come out to others and to appear as women" regardless of their own feelings on the matter. While it illuminates an area in which therapists would do well to be cautious, it also indicates some positive departure from earlier attitudes, which, far from pushing a client to transition, regularly characterized them as hysterical (Finney, Brandsma, Tondow, & Lemaistre, 1975).

Another significant finding that arose from these interviews is the frequency with which trans and genderqueer clients have felt pushed into the role of educator within their therapeutic relationships. Though their feelings about this dynamic varied, the majority of participants stated that they had at some point felt compelled to educate their therapists about issues relating to the trans community. Although the most recent literature offers multiple

suggestions on ways to increase one's professional knowledge about the trans community, asking one's clients to provide this information is not commonly found among these. It is interesting, therefore, how common a phenomenon this seems to be among this group of participants.

Overall, the majority of people interviewed expressed positive feelings about at least one of their therapists, with four participants specifically citing a therapist as a major supportive influence through the transition process. This again illustrates the degree to which clinical attitudes towards transpeople have clearly evolved since the earliest articles described in the literature review above, as well as the potential value of the therapeutic relationship itself for someone in transition. While individual therapists were seen as caring, genuinely helpful, and empathetic, clients expressed significantly increased wariness or outright distrust of the larger mental health system as well as the professional medical community. The perception remains for the majority of these participants that the larger medical and mental health institutions of this country, including insurance companies, psychiatrists, medical doctors, and prominent researchers are largely hostile towards transpeople, with a tendency to pathologize and compartmentalize their experiences. Again and again, the existing standards of care and the resulting expectations they impose upon those who fall under their

umbrella were described in interviews as major impediments to the establishment of trust in a therapeutic relationship.

According to these findings, this dynamic of distrust came to a head for many people around the issue of the therapist's letter. Previous studies have indicated that the gatekeeper role traditionally played by therapists is likely to result in transgender clients who may be "less than forthcoming" about, for instance, the severity of their depression for fear that a letter may be denied (Carroll, Gilroy & Page, 2002). These findings are overwhelmingly confirmed by responses to this study, as eleven participants expressed negative feelings about the gatekeeper role itself, while nine specifically stated that they felt the honesty of the therapeutic relationship was negatively impacted by this gatekeeping dynamic.

Perhaps still more significant are the implications of this trend; if clients feel compelled to downplay their distress or streamline their stories in order to match themselves to the dominant narrative (and thereby obtain the letter that will provide a passport to surgery), therapists and researchers will continue to compile inaccurate data that in turn supports the false narrative that currently acts as reference point for letter eligibility. There is a vicious cycle here that seems to undermine any genuine attempt to build on the current body of

research through the gathering of data obtained during psychotherapy sessions; the degree to which transpeople feel compelled to create false narratives calls into question the efficacy of using existing narratives to define a "true" transsexual. In a 2004 sourcebook for clinicians, Lev writes: "Since approval for treatment rests on one's conformity to the diagnostic criteria, there is a strong desire on the part of transgendered clients seeking hormonal and surgical treatment to 'fit' the outlined criteria." For clients who do not fit this criteria but who nonetheless desire surgery or hormones, there seems to be little choice but to lie. Participants in this study, in critiquing the current model of provision of care, echo another author who asks: "Should medical technologies continue to be available only to a narrowly defined class of persons…with mental health professionals having the responsibility and privilege of deciding who does and does not qualify to receive it? (Denny, 1996)"

This question is clearly not an easy one to answer; even those who most avidly questioned existing protocols were often quick to add that they do not believe that there should be *no* support system in place to ensure that individuals are emotionally and psychologically ready for what can be invasive and life-changing surgical procedures. This suggests an area for further research in which more inclusive methods might be developed and dynamics shifted to

allow for a therapeutic relationship undamaged by the looming awareness of the gatekeeping role and all that it entails.

With regard to the inclusion of gender identity disorder itself as a diagnosis in the DSM, responses within this study were similarly strong. Again, the majority of the respondents were in line with current trans-positive literature that calls for an overhaul of the current diagnostic system and often cites removal of the GID diagnosis as the first step towards meeting this goal (Bornstein, K., 1994, Green, J., 1994, Wilchins, R., 1997). Aside from their desire for more inclusive labeling, most participants in this study took issue with the fact that their identities were characterized as mental illness. Many did acknowledge the very real distress and secondary difficulties commonly faced by trans and genderqueer people, but stated that they believed that the diagnostic formulation of these difficulties ought to focus on the repercussions of persistent discrimination, rather than identifying individual pathology as the culprit. This point of view not surprisingly represents a significant departure from earlier literature (Lothstein, 1982, Rekers, 1977, Rekers & Lovaas, 1974), which was typically quick to correlate symptoms of depression, anxiety, narcissism, and hysteria with a client's persistent wish to alter her/hir/his assigned sex.

In their responses to the given questions, participants in this study showed themselves to be informed consumers with regards to their own mental health care, making use of community networks and resources to access competent, affirmative care. Through the negative experiences that they and their friends have undergone, they have developed ways to navigate the mental health system in order to obtain the care they need. It is perhaps in part due to this astuteness in provider selection that the vast majority of participants reported at least one 'positive' or 'very positive' therapeutic relationship. This also suggests that clinicians themselves, at least in the relatively liberal region of the Northeast U.S., have become more sensitive to the particular needs of this population since awareness of trans identities began to enter the mainstream.

Although there remain reports of therapists who are insensitive, judgmental, or outright unethical, and therapists who push religious doctrine or rigid identities onto their clients, this study suggests that for the most part, client frustrations center around the larger mental health system rather than the individual therapist. If the system itself allowed for more fluidity and removed any pejorative implications, several respondents suggest, individual therapists would have better guidelines and resources available to them upon which to rely when working to educate themselves about their clients. Finding a method of

changing the current system both of diagnostic criteria and of the gatekeeping role played by therapists in the writing of surgical letters would be an important and valuable area for future research. As the contents of this study's interviews (along with much of the current literature) indicate, an alteration of this system would be more complicated than a mere removal of the current guidelines. What is called for is a way in which a supportive system can be instated that acknowledges trans identities and enables the acquisition of funding for true, unbiased research without imposing pathology or limiting the options of clients who accept the label of a trans identity.

In addition to the research proposed above, this study had several limitations that in turn suggest further directions for expanded inquiry. The relatively small sample size and overall shortage of racial, ethnic, and socioeconomic diversity limits the degree to which its findings can be generalized to a larger population. In addition, the geographic location in which this study was conducted is generally marked by progressive, liberal politics; results of a similar study conducted in a more conservative region of the country or among a population without the resources to pick and choose among a variety of therapists might yield very different results.

Several points raised by participants in this study also suggested areas for research beyond the scope of this project. While participants generally reported fairly positive experiences in therapy, many also stated that these experiences stood in stark contrast to treatment they had received in search of medical care. Three participants specifically mentioned that the area that they felt needed the most reform was the medical establishment, where they have felt consistently judged, been asked inappropriate questions, or been denied appropriate care due to a hospital or physician's lack of knowledge about their bodies or identities.

The standards of care defining treatment options for transgender and gender-variant clients have been steadily evolving as general awareness has increased. This study demonstrates the strides that have been made since early literature invalidated trans identities and pathologized its participants' motivations. The responses of these participants also illustrates the resiliency of gender-variant individuals as a community and the success with which grass-roots organizations (many making use of the internet) have build impressive banks of resources and information. At the same time, it is clear from the shared frustrations of these respondents that there is more work to do before people whose gender identities fall outside the narrowly defined norm can feel fully respected in their identities and can feel confident that they will not be

mistreated by individuals or systems simply because their sense of self is more complex than the role assigned to them.

References

Anastas, J. (1999). *Research design for social work and the human services*. New York: Columbia University Press

Bockting, W.O., Knudson, G., & Goldberg, J. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3/4), 35-82.

Bornstein, K. (1994). *Gender outlaw: On men, women, and the rest of us*. New York: Vintage Books.

Burdge, B. J. (2007). Bending gender, ending gender: Theoretical foundations for social work practice with the transgender community. *Social Work, 52*(3), 243-250.

Carroll, L. & Gilroy, P. (2002). Transgender issues in counselor preparation. *Counselor Education and Supervision, 41*(March), 233-242.

Carroll, L., Gilroy, P. & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling & Development, 80*(2), 131-140.

Dean, L., Meyer, I, Robinson, K., Sell, R., Sember, R., Silenzio, V., Bowen, D., Bradford, J., Rothblum, E., White, J., Dunn, P., Lawrence, A., Wolfe, D., & Xavier, J. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association*, *4*(3), 102-151.

Denny, D. (1996). In search of the 'true' transsexual. *Chrysalis: The Journal of Transgressive Gender Identities*, *2*(3), 39-48.

Ettner, R. (1996). *Confessions of a gender defender: A psychologist's reflections on life among the transgendered*. Evanston, IL: Chicago Spectrum Press.

Finney, J. C., Brandsma, J. M., Tondow, M. & Lemaistre, J. (1975). A study of transsexuals seeking gender reassignment. *American Journal of Psychiatry*, *132*(9), 962-964.

Gagnes, P. & Tewksbery, R. (1997). Coming out and crossing over: Identity formation and proclamation in a transgender community. *Gender and Society*, *11*, 478-508.

Glenn, W. (1999). Reflections of an emerging male-to-female consciousness. *Journal of Gay and Lesbian Social Services*, *10*(3/4), 83-94.

Green, J. (2004). *Becoming a visible man*. Tennessee: Vanderbilt University Press.

Hale, C. J. (2007). Ethical problems with the mental health evaluation standards of care for adult gender variant prospective patients. *Perspectives in Biology and Medicine, 50*(4), 491-505.

Hanssmann, C., Morrison, D. & Russian, E. (2008). Talking, gawking or getting it done: Provider trainings to increase cultural and clinical competence for transgender and gender non-conforming patients and clients. *Sexuality Research and Social Policy*, *5*(1), 5-23.

Hausman, K. (2003). Controversy continues to grow over DSM's GID diagnosis. *Psychiatric News*, *38*(14). 25.

Hill, D. B. (2005). Trans/gender/sexuality: A research agenda. *Journal of Gay & Lesbian Social Services, 18*(2), 101-109.

Hines, S. (2007). Transgendering care: Practices of care within transgender communities. *Critical Social Policy, 27*(4), 462-486.

Israel, T., Gorcheva, R., Walther, W., Sulzner, J., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice, 39*(3), 361-368.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: Haworth Press.

Lothstein, M. (1982). Sex reassignment surgery: Historical, bioethical, and theoretical issues. *American Journal of Psychiatry*, *139*(4), 417-426.

Mallon, G.P. (1999). Knowledge for practice with transgendered persons. *Journal of Gay & Lesbian Social Services, 10*(3/4), 1-18.

Meyer, W. J., Bockting, W. (2002). The Harry Benjamin international gender dysphoria association's standards of care for gender identity disorders, 6th edition. *Journal of Psychology and Human Sexuality, 13*(1), 1-30.

Nordyke, S., Baer, D., Etzel, B. & LeBlanc, J. (1977). Implications of the stereotyping and modification of sex role. *Journal of Applied Behavior Analysis, 10*(3), 553-557.

Pazos, S. (1999). Practice with female-to-male transgendered youth. *Journal of Gay and Lesbian Social Services*, *10*(3/4), 65-82.

Rekers, G. (1977). Atypical gender development and psychosocial adjustment. *Journal of Applied Behavior Analysis, 10*(3), 559-571.

Rekers, G. & Lovaas, O. (1974). Behavioral treatment of deviant sex-role behaviors in a male child. *Journal of Applied Behavior Analysis, 7*(2), 173-190.

Ruby, J. & Mantilla, K. (2000). Men in ewes' clothing: The stealth politics of the transgender movement. *On Our Backs*, *30*(4), 5.

Russell, G. M. & Bohan, J. S. (2007). Liberating psychotherapy: Liberation psychology and psychotherapy with LGBT clients. *Journal of Gay & Lesbian Psychotherapy, 11*(3/4), 59-75.

Socarides, C. (1969). The desire for sexual transformation: A psychiatric evaluation of transsexualism. *American Journal of Psychiatry*, *125*(10), 125-131.

Spiegel, A. (Writer). (2008, May 7). Two families grapple with sons' gender preferences. [Radio broadcast episode]. On J. Kern (Producer), *All Things Considered*. Washington, D. C., National Public Radio.

Wilchins, R. A. (1997). *Read my lips: Sexual subversion and the end of gender*. Michigan: Firebrand Books.

Wright, K. (2001). To be poor and transgender. *The Progressive*, October 2001, 3-5.

Zucker, K.J. & Bradley, S.J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents.* New York: Guilford Press.

APPENDIX A

HUMAN SUBJECTS REVIEW BOARD APPROVAL LETTER

December 28, 2008

Hunter Smith

Dear Hunter,

Your amended materials have been reviewed. You have done a very thoughtful and careful job in their revision and all is now in order. You were particularly thoughtful in removing any sign of bias in your presentation and have adopted the position of an interested and open minded researcher. We are happy to give final approval to your interesting study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Cara Segal, Research Advisor

APPENDIX B

SCREENING QUESTIONS

1) Where did you hear about this study?

2) What made you decide to participate in this study?

3) Do you understand that participation in this research project is voluntary and can be withdrawn at any time during the interview process?

4) Are you 18 years of age or older?

5) Do you speak and understand English?

6) Are you able to give independent legal consent to participate in a project of this nature?

7) Have you, currently or any time in the past, had experience in one-on-one therapy for any length of time?

8) Do you have any special needs that I will need to take into account in arranging an interview?

9) Do you have any preliminary questions for me before we set up a meeting?

APPENDIX C

INFORMED CONSENT FORM

2/11/09

Dear Interview Participant,

My name is Hunter Swanson and I am a second-year graduate student at the Smith School for Social Work (SSW), and I am conducting a study exploring the experiences of trans and genderqueer people within the mental health system. I am interested specifically in speaking with people whose identities have at some point fallen outside the traditional expectations associated with their assigned (birth) sex, and in hearing how they have perceived their experiences with therapists, social workers, or other mental health providers. I am hoping to compile data that will reflect the ways in which mental health workers' perceptions of their clients' gender identities impact the level of care received by those clients, and that will allow the perspective of the clients themselves to define strengths, deficits, and areas in which further sensitivity or education is needed on the part of these providers. I will be using all data gathered throughout this study in the formulation of my MSW thesis for the Smith SSW; as such, it will be included in all related demonstrations and presentations. In addition, data may also be used for additional presentations and/or publication.

In order to be eligible for participation in this study, you must be an English-speaking adult (18 or older) who is able to provide consent and who has at some point seen a mental health provider for individual therapy. I am looking for individuals who, as described above, identify as trans or genderqueer, or feel as though their gender identity falls outside of traditional boundaries. Through participating in this study, you will be asked to sit for a one-on-one interview lasting approximately one hour. All interviews will be audio-recorded using a small hand-held device and later transcribed (by myself) into written format. At no point in time will your name be associated with the information you provide; participants will be identified by number, and identifying details not relevant to the data will be changed to protect confidentiality. During this interview, I will be asking you a series of questions that are open-ended and centered upon your

memories of gender identity development as well as your interactions with mental health systems (and your feelings about those interactions).

Risks involved in this study include the potential for emotional distress engendered by speaking in detail about potentially upsetting personal experiences. I will provide each participant with a list of local resources that can provide additional support, should you feel the need to seek such support after the study's conclusion. I will also provide my email address to enable you to contact me with any concerns or comments that may come up after the interview itself.

While there is no direct compensation offered for participation in this study, it does provide an opportunity to help give a voice to a demographic whose experiences have tended to be marginalized. The benefits of your participation include the chance to aid in the effort to gain increased respect and sensitivity from the mental health professions and to give clinicians a broader and more accurate perspective on the experiences of their trans and genderqueer clients.

As mentioned above, at no time will your name be associated with any data you may provide; participants will be identified by code numbers in written transcripts and all identifying data will be changed to prevent potentially compromising confidentiality. While transcribing of interviews will be done only by myself, my research advisor will additionally have access to the materials after identifying information has been removed. In publication or for the purpose of presentations, in any instance in which brief illustrative quotes are used, they will be carefully disguised to further protect your identity. All data gathered for the purpose of this study will be kept for three years (as required by Federal guidelines) in a secure, locked location, after which time they will be destroyed. Electronic data will similarly be protected and destroyed after three years have elapsed.

Additionally, it should be indicated that participation in this study is entirely voluntary, and reiterated that participation can be withdrawn at any point during the data collection process. You may also choose not to answer any question(s) in the interview without penalty. If you choose not to complete the interview, any recorded information will be destroyed and will not be included in the study. If after the conclusion of the interview you decide to withdraw

your consent, you can contact me any time before 5/01/09. At that time, all data relating to you will be destroyed and will not be included in the final work. After the final date, however, it will no longer be possible to remove your data from the project, as it will have been incorporated (with confidential safeguards in place) into the final paper. If you have any questions or should you wish to withdraw from the study, you can contact me by phone at (718) 219-6619 or through email at hsmith@email.smith.edu. In addition, if you have any concerns about your rights or more generally about any aspect of this study, you can contact me directly or call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of
Participant:_____Date:_____

Signature of
Researcher:_____Date:_____

Please keep a copy of the consent for your records

Hunter Swanson
(718) 219-6619 cell
Hsmith@email.smith.edu

APPENDIX D

ADDITIONAL RESOURCES

Massachusetts Trans Resources

http://www.jri.org/Programs-Additional-Adolescent-Programs-Sidney-Borun-Health-Center.php

The Sidney Borum, Jr. , Health Center provides a full range of primary care, mental health and substance abuse counseling, HIV counseling, testing and risk reduction reinforcement, and other clinical and social services to young people, generally between the ages of 13 and 29.

Our primary focus is on persons who fall outside of more traditional healthcare settings for a variety of reasons, homelessness; involvement in street life and the sex industry; placement in a residential facility or group home because of serious social and behavioral dysfunction, multiple placements with DSS so that medical care and healthful life style have been disrupted; and being gay, lesbian, bisexual, or transgender and, therefore, at risk of not receiving culturally and clinically appropriate services.

The Sidney Borum Health Center is located at 130 Boylston Street in Boston, MA and is open on Monday and Friday from 9:00 a.m. to 5:00 p.m., and on Tuesday through Thursday from 9:00 a.m. to 7:00 p.m. Urgent Care walk-in hours are Monday through Friday from 1:00 p.m. to 4:30 p.m. To schedule an appointment or apply for health care coverage, please contact Patient Services at 617.457.8140

http://www.fenwayhealth.org/site/PageServer

For nearly forty years, **Fenway Community Health** has been working to make life healthier for the people in our neighborhood, the LGBT community, people living with HIV/AIDS and the broader population. **The Fenway Institute** is an interdisciplinary center for research, training, education and policy development focusing on national and international health issues.

Hours of Operation

Fenway Community Health
7 Haviland Street
(617) 267-0900

Medical and Complementary Therapies
Monday - Thursday, 7:30 a.m. - 8:00 p.m.
Friday - 7:30 a.m., 7:00 p.m.

Behavioral Health
Monday - Friday, 8:00 a.m. - 8:00 p.m.

Lifecourse Counseling Center
P.O. Box 845
Northampton, MA 01061-0845
info@lifecourse.net
(413) 585-1655
www.lifecourse.net

***Pride Zone* Northampton**
http://www.pridezone.org
A *youth center* for gay, lesbian, bisexual, transgender, queer, questioning and straight
youth ages 22 and under. Open 3-4 nights a week and host a number of support groups, events and will soon be opening an tutoring and life-skills management program. 34 Maplewood Shops (Basement Space, next to Northriver Rentals) Northampton, MA, przone@valinet.com 413-584-1116

***The East Coast Female-to-Male Group* (ECFTMG) - Northampton**
ECFTMG meets in Northampton, Massachusetts every month. All FTMs and SOFFAs are welcome, of all sexual orientations and whether non-op, pre-op, post-op, crossdressers, or questioning. The group is a *free peer support group* meeting regularly since 1992. To receive a list of ongoing meeting dates and discussion topics, write to: ECFTMG, P.O. Box 60585, Florence, MA 01062.

The Sunshine Club
P.O. Box 564
Hadley, MA 01035-0564

Phone: (413) 586-5004
Email: av517@osfn.org http://www.thesunshineclub.org/
A non-sexual support organization that was founded to support, and provide knowledgeable education and information about, the transgendered community.

Web-Based Trans Resources

http://www.gender.org/
Gender Education and Advocacy (GEA) is a national organization focused on the needs, issues and concerns of gender variant people in human society. We seek to educate and advocate, not only for ourselves and others like us, but for all human beings who suffer from gender-based oppression in all of its many forms. We also are a 501(c)(3) non-profit organization incorporated in Georgia.

http://www.tsroadmap.com/

http://www.trans-forumresearch.com/
Trans-Forum Research is dedicated to facilitating studies in the gender and sexuality arena. Through its efforts, Trans-Forum Research hopes to transform the way in which research is conducted in the field of gender, sexuality, HIV/AIDS and other areas (inter-sexuality, substance abuse, depression, violence, stigma, homophobia, discrimination, and others). The Trans-Forum Research site acts as a resource by hosting online studies, and in doing so, brings together two communities - the research/academic/medical professional and the participant communities, including Gay, Lesbian, Bisexual, and Transgender, i.e., GLBT communities. The mission of Trans-Forum Research is to support growth of gender and sexuality studies, and ultimately contribute to society's awareness and knowledge of these issues. It is hoped that this will be achieved through participation on the part of relevant communities.

http://www.nctequality.org/
The National Center for Transgender Equality (NCTE) is a 501(c)3 social justice organization dedicated to advancing the equality of transgender people through advocacy, collaboration and empowerment. NCTE was founded in 2003 by transgender activists who saw the urgent need for a consistent voice in Washington DC for transgender people. NCTE provides this presence by

monitoring federal activity and communicating this activity to our members around the country, providing congressional education, and establishing a center of expertise on transgender issues. NCTE also works to strengthen the transgender movement and individual investment in this movement by highlighting opportunities for coalition building, promoting available resources, and providing technical assistance and training to transpeople and our allies.

http://www.ftmi.org/

FtM International – resources for female-to-male transpeople

http://www.ifge.org/

IFGE advocates for freedom of gender expression.
We promote the understanding and acceptance of **All People:** Transgender, Transsexual, Crossdresser, Agender, Gender Queer, Intersex, Two Spirit, Hijra, Kathoey, Drag King, Drag Queen, Queer, Lesbian, Gay, Straight, Butch, Femme, Faerie, Homosexual, Bisexual, Heterosexual, and of course – You!

http://www.lgbthealth.net

National Coalition for LGBT health

APPENDIX E

INTERVIEW GUIDE

1) Are there any questions you have for me before we begin?

2) How old are you?

3) How do you identify in terms of race and ethnicity?

4) How would you describe your gender identity? What does that mean to you? (what are your preferred pronouns?)

5) How would you identify in terms of sexual orientation?

6) What is your educational background?

7) If you feel comfortable doing so, tell me a bit about your gender identity development.

8) How well would you say your inner sense of self matches what others see? What do you think are the reasons for this? Do you think strangers perceive you differently than friends or family members? Coworkers? Partners?

9) Do you feel your gender presentation differs in different situations?

10) How fluid or fixed do you feel your gender is? Does it vary from day to day? Year to year? Little or never?

11) In what ways do you think your gender affects your day-to-day life? (i.e. work, socializing, activism, relationships)

12) How often would you say you've experienced discrimination or other negative
repercussions stemming from your gender identity or presentation? Give some examples if you'd like.

13) How much time have you spent in therapy or other mental health treatment? (number of therapists seen)

14) What were your initial reasons for seeking out mental health treatment? Have those reasons changed over time?

15) What have your experiences in therapy been like?

16) Have you ever been in the position of asking a therapist for a letter in order to obtain hormones or surgery? If so, what was that experience like?

17) Do you have any feelings about the 'gatekeeper' role that therapists can play in providing letters?

18) How informed do you feel your therapist(s) have been about trans/gender issues? Have you ever had to play the role of educator with your therapist?

19) Do you think your gender identity has affected the quality of care you've received, or impacted your relationship with any of your therapists? How?

20) Are there any ways you imagine your experience might have been different if your gender identity/presentation was more/less traditional?

21) What, if anything, have therapists or mental health workers, or agencies done to make you feel safe and respected?

22) What, if anything, have therapists, mental health workers, or agencies done to make you feel invalidated, unsafe, or uncomfortable?

23) What (if anything) do you wish these people/agencies had known or done differently that would have improved the quality of care you received?

24) What do you think are some important things for clinicians to know when working with genderqueer, trans, and gender non-conforming clients? What are the biggest mistakes you think they make when dealing with this population?

25) What are some things that you think agencies could do to make themselves more welcoming to trans/genderqueer/gender non-conforming clients?

26) What, if any, are your feelings about the inclusion of Gender Identity Disorder in the DSM?